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- (ii) Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work (including workers who work outside of a hospital and have frequent contact with blood or other infectious secretions); and
- (iii) Heterosexually active persons with multiple sexual partners (that is, those Medicare beneficiaries who have had at least two documented episodes of sexually transmitted diseases within the preceding 5 years).
- (3) Exception. Individuals described in paragraphs (a) (1) and (2) of this section are not considered at high or intermediate risk of contracting hepatitis B if they have undergone a prevaccination screening and have been found to be currently positive for antibodies to hepatitis B.
- (b) Blood clotting factors: Conditions. Effective July 18, 1984, blood clotting factors to control bleeding for hemophilia patients competent to use these factors without medical or other supervision, and items related to the administration of those factors. The amount of clotting factors covered under this provision is determined by the carrier based on the historical utilization pattern or profile developed by the carrier for each patient, and based on consideration of the need for a reasonable reserve supply to be kept in the home in the event of emergency or unforeseen circumstance.
- (c) Blood clotting factors: Furnishing Fee. (1) Effective January 1, 2005, a furnishing fee of \$0.14 per unit of clotting factor is paid to entities that furnish blood clotting factors unless the costs associated with furnishing the clotting factor are paid through another payment system, for example, hospitals that furnish clotting factor to patients during a Part A covered inpatient hospital stay.
- (2) The furnishing fee for blood clotting factors furnished in 2006 or a subsequent year is be equal to the furnishing fee paid the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

[55 FR 22790, June 4, 1990; 55 FR 31186, Aug. 1, 1990, as amended at 69 FR 66422, Nov. 15, 2004; 77 FR 69363, Nov. 16, 2012]

§ 410.64 Additional preventive services.

- (a) Medicare Part B pays for additional preventive services not described in paragraph (1) or (3) of the definition of "preventive services" under §410.2, that identify medical conditions or risk factors for individuals if the Secretary determines through the national coverage determination process (as defined in section 1869(f)(1)(B) of the Act) that these services are all of the following:
- (1) Reasonable and necessary for the prevention or early detection of illness or disability.
- (2) Recommended with a grade of A or B by the United States Preventive Services Task Force.
- (3) Appropriate for individuals entitled to benefits under part A or enrolled under Part B.
- (b) In making determinations under paragraph (a) of this section regarding the coverage of a new preventive service, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such services and may take into account the results of such an assessment in making such national coverage determinations.

[73 FR 69933, Nov. 19, 2008, as amended at 75 FR 73615, Nov. 29, 2010]

§ 410.66 Emergency outpatient services furnished by a nonparticipating hospital and services furnished in a foreign country.

Conditions for payment of emergency inpatient services furnished by a non-participating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

[71 FR 48136, Aug. 18, 2006]

§410.68 Antigens: Scope and conditions.

Medicare Part B pays for-

- (a) Antigens that are furnished as services incident to a physician's professional services; or
- (b) A supply of antigen sufficient for not more than 12 months that is—
- (1) Prepared for a patient by a doctor of medicine or osteopathy who has examined the patient and developed a